Effective Doctor Patient Communication: Building Bridges and Bridging Barriers

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ABSTRACT: The headache history is discussed as a model for establishing effective doctor patient communication. A thorough knowledge regarding headache onset, course and current features provides a basis for diagnosis and management. The principles of acceptance, validation, empathy, respect and advocacy are explored.

RÉSUMÉ: Communication médecin-patient efficace: construire des ponts et surmonter des obstacles. L'histoire de la céphalée est exposée comme modèle d'fune communication médecin patient efficace. Une bonne connaissance du mode de début, de l'évolution et des caractéristiques actuelles de la céphalée constitue la base sur laquelle le diagnostic et le traitement sont établis. Les principes d'acceptation, de validation, d'empathie, de respect et d'intercession sont explorés.

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Migraine … the most misunderstood, misdiagnosed, and mistreated disorder of modern medicine.
Seymour Diamond
Newsweek, January 11, 1999

Over the last 20 years there have been remarkable advances in the understanding of the pathophysiology of migraine. This has clearly shown migraine to be a disorder of the brain and has led to potent treatments in the form of triptan medications. Specific criteria for the diagnosis of migraine and other headache disorders have been agreed upon internationally, standardizing research and facilitating clinical diagnosis. The Canadian Headache Society has published guidelines for diagnosis and management of migraine. Migraine is now receiving greater scientific attention than at any time in the long history of the disorder.

Despite these advances major challenges remain for people afflicted with migraine. There remains a lack of awareness regarding the degree of suffering many patients with migraine endure not just during individual attacks but as a chronic disorder impacting on education, career, and family. The belief that migraine is more psychological than physiological continues to be held by many physicians.

For many, even the diagnosis remains elusive either through not seeking medical attention or being diagnosed incorrectly with disorders such as sinusitis, tension headache, or "stress headache". Even when correctly diagnosed migraine management may be compromised by physicians being unaware of the wide array of treatment options available.

One of the keys in rectifying the inadequacies in migraine management is to improve the communication between family physicians and migraine patients. Learning to take a headache history and then using it can provide the physician with a formidable tool to improve not only diagnosis but also doctor-patient communication. The approach presented here is from the perspective of a headache specialist having the luxury of time, a commodity in short supply in the busy family physician's office. However, for most patients with headache this may not present an insurmountable difficulty, as they will usually not have the complexity seen in specialty practice.

The principles are no different than those used the history to make a diagnosis for any other medical complaint. However, there are nuances necessary in an attempt to address concerns unique to a chronic disorder that may have taken a toll over many years. As well, some patients may have been subjected to poor doctor-patient experiences in the past. A brief review of Internet newsgroups and information gleaned from various headache surveys done in North America will attest to this unfortunate reality.

The headache history

Headache is a symptom rather than a diagnosis. The history is a vital tool in diagnosing each headache type that a patient may suffer from. For many patients this may be a recurring pattern

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easily diagnosed as migraine. For others there may be multiple headache diagnoses such as migraine and tension-type headache with or without medication overuse. Physicians must be aware of the patterns of the primary headaches and be alert to warning signals for secondary headaches that might require further evaluation with imaging or other investigation.

Headache onset

The onset of the headache problem may be important information for diagnosis. A history of headache beginning in childhood is often a marker for migraine in adult years. In females, headache onset at the time of hormonal changes such as menarche, use of birth control pills or hormone replacement in perimenopause and pregnancy are all highly suggestive of migraine. Headaches that recur monthly at the time of menstruation are pathognomonic for migraine.

Other important historical features include the role of head or neck trauma. There is usually a clear temporal association between injury and the development of headache. However, in some cases only careful inquiry suggests a diagnosis of post-traumatic headache. The ability of neck trauma to aggravate a mild pre-existing migraine tendency or result in headache mimicking migraine may influence treatment options and outcomes.

Headaches beginning in later years are much less likely to be related to primary causes. Secondary headaches are more likely and may be related to cervical osteoarthritis, temporal arteritis, or intracranial disorders.

Longitudinal history

To fully understand the nature of the disorder it is important to attempt to construct a history beginning from headache onset through until the present time. This may aid diagnosis of migraine when features such as complete relief during pregnancy or worsening with the onset of perimenopausal symptoms are present. Headache occurring for periods of weeks or months followed by complete freedom is often a marker for episodic cluster headache.

Transformational migraine may be diagnosed based on a gradual worsening over time beginning with an occasional episode evolving into a chronic daily headache pattern. During the transformational period, the role of medications may suggest medication-induced headache. This disorder is commonly encountered in patients with chronic daily headache and will usually be refractory to treatment until the overused medications are withdrawn.

The history may well traverse some difficult times in the patient's life. Struggling with headache during school years or with a young family may have occurred without empathy or support from family or health care providers. Headaches may have been severe and frequent enough to affect career decisions, interfere with relationships, or result in decisions to not pursue having a family. All of these possible challenges are important for physicians to learn of, to more fully understand the impact on the patient.

The investigation and treatments offered over time may influence strategies to be employed against the current headache condition. Experiences with physicians in an office setting or the Emergency Department may present difficulty in acquiring trust in future management. The use of opioids may have resulted in negative interactions and accusations of addiction despite this rarely occurring in the headache population.

The Current Headache History

The characteristics of each of the headaches the patient is presenting with will usually allow diagnosis when the information regarding onset and the longitudinal features are known. There are easily applied diagnostic criteria for all primary headaches to facilitate this process further.

For each headache, the frequency, severity and duration is important in deciding on a treatment approach. Trigger factors may further aid diagnosis and may be a first step in treatment. The impact of headache on the life of the patient must be understood within the context of their relationships, family life and work.

How is the patient currently managing their headache disorder? Does the patient understand what may trigger headaches and do they take the steps necessary to minimize their exposure to avoidable triggers? Is effective and appropriate medication available to treat headache events and are they taken in a timely fashion? Does the patient understand the role of different medications for either acute or preventative treatment? Is there sufficient support and understanding from those in the home or at work? Does the patient have a clearly defined strategy to control their disorder? These are all important questions in assessing the ability of the patient to manage their headache disorder and show where deficiencies may be addressed.

The art of the headache history

During history taking, a unique opportunity exists to build a relationship based on a thorough understanding of all aspects of the headache disorder. Many patients feel a need to "prove" that they have pain and are relieved to have their complaints accepted. Patients with chronic daily headache may function in an outwardly normal fashion despite mild to moderate discomfort. This should not suggest the absence of pain nor alter the impact of pain reported by the patient. Accepting the account of pain at face value with a nonjudgemental approach will best serve management in the vast majority of cases.

The ability to listen and express empathy when appropriate is important. Many headache patients have had their disorder have great impact on them often during difficult times in their life. Statements such as "That must have been hard for you" or "That must have been a difficult time" suggest an understanding on the part of the physician of the importance of headache in the life of the patient. Many patients have not only survived but have successfully pursued education, career, and family goals. They should be afforded the deserved respect in being able to persevere despite the adversity of headache.

Validating the headache disorder is necessary for many patients. To accept that headache is "real", not a behavioural or psychogenic disorder may correct long held beliefs within the patient. Physicians and family suggesting that stress was causative and that, in many ways, the patient was responsible for

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their headache disorder, may have reinforced these beliefs. For patients with migraine, the knowledge that the disorder is an inherited condition of the brain helps redefine the understanding of their headaches as a first step in treatment. A brief description of the pathophysiology involving the brain and blood vessels underscores migraine as a valid medical disorder. This should be prefaced by reassurance that, despite the severity of the headaches, a serious underlying cause is not present. This can be re-enforced through describing the process for diagnosis including the criteria used for migraine, cluster, or other primary disorders. In some cases imaging may be necessary to alleviate concerns of the patient and family.

One of the roles physicians may be required to play is that of an advocate for the patient. Spouses and other family members may not have a complete understanding that may impair their ability to be supportive. The employer may need to be encouraged to provide concessions or modifications to the employee with headache. A description of the unpredictable and severe nature of migraine may help explain absenteeism. The environment may be detrimental with the presence of fluorescent lighting, perfume use by other employees, or a poor workstation. Shift work may result in sleep disruption and an increase in headache activity.

At times the physician may be called upon to assist patients to acquire benefits from insurance companies or act as a consultant to lawyers. Those with severe disorders may not be able to be employed or continue on with their employment. This will require documentation regarding the impact of headache on the patient's ability to work, based on the assessment during the headache history. The use of headache calendars and disability tools may be useful measures for these opinions.

Conclusion

Effective doctor-patient communication for the management of headache begins with the headache history. This can be used as more than a tool for diagnosis but also as the framework for addressing many aspects of the disorder. The ability to understand the impact of headache requires a longitudinal approach to history taking, beginning with the time of onset followed by the course over the time period before the current state. The physician should adopt an accepting attitude to the report of headache and attempt to validate headache as a valid medical problem. Empathy and respect for the impact of headache in the life of the patient will further enhance the quality of communication. The application of these principles will result in a more co-operative relationship in the management of the headache disorder.

Suggested reading

Silverman J, Kurtz S, Draper J. Skills for Communicating with Patients. Radcliffe Medical Press 1998.
This book provides an explanation of the core skills needed to enhance doctor-patient communication. The evidence base in support of these methods in improving health outcomes is presented.

Pryse-Phillips WEM, Dodick DW, Edmeads JG, et al. Guidelines for the diagnosis and treatment of migraine. CMAJ 1997; 156(9) 1273-1287.
These guidelines are based on the previously published International Headache Society criteria for migraine diagnosis. The treatment approach was developed through a review of the available evidence base and expert consensus.

Rapoport AM, Sheftell FD. Headache Disorders: A Management Guide for Practitioners. WB Saunders and Company, Philadelphia PA, 1996.
These authors provide a highly practical and informative overview of headache medicine for physicians involved in primary care.

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